Illinois Rural HealthNet

Improving health care through connectivity

FCC Rural Health Care Support Mechanism
Notice of Proposed Rulemaking
WC Docket No. 02-60
September 1, 2010
Submitted by Illinois Rural HealthNet
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Comments are listed by Topic Area, and then by Paragraph Number as provided in the Notice of Proposed Rulemaking (NPRM) of July 15, 2010

- ***I. Comments that impact upon the financial viability of Rural Health Care Networks:***

The impediment to the development of high speed connectivity for rural health care has been the high cost of improved networks in areas where the potential number of customers, and return on investment, are, by definition, limited. The NPRM includes multiple concepts that can improve the business case.
Paragraphs 67 through 82 on Shared Use.
The objective of these paragraphs is to find ways to improve the business case for building high speed health-oriented networks, without subsidizing unauthorized uses.Our comment proposes as follows:

1. Any excess capacity built into a health care network is made available on a wholesale basis to users and also to broadband service providers.
2. All net profits for the network that arise from such excess capacity (after legitimate network expenses are paid) shall be used by the health care provider network for network sustainability and network growth.

Paragraph 69: Fully-Distributed and Incremental Costs.

1. All entities which are involved at the front end of the network build shall share the cost of the build proportionately to their share of the network assets or services. The health care funding shall pay for the initial build and the allowable excess capacity. If other non-health entities are interested, at the outset of the procurement process, in participating, such non-health entities should pay for their fully allocated costs, including construction.
2. Any entities which choose to make use of the network assets or services *after* such time as the network has been built shall pay a reasonable cost based on:
    a. The incremental cost for the new entity to use the assets or services; and
    b. A fee to use the network backbone.
    c. The regular and recurring monthly fees for network maintenance and an equipment-refresh fund.
3. The net profits (that are due to the network as a whole) from all such "new" entities shall be used for network sustainability and growth.

Paragraph 37: Administrative Expenses.
Comment: The eligibility of Administrative Expenses is strongly supported. It is recommended that the legal review of contracts be included in the eligible category.

Paragraphs 44 and 45: Seeks comment on Minimum Participant Contribution, and raising it.
Comment: The current 15 percent match has been proven difficult for about half the Pilot Participants. The match amount should not be increased.
Paragraph 47: Seeks comment on limitation of Eligible Sources for the matching funds.
Comment: The recommendation is that in-kind contributions, reasonably but measurably defined, should be eligible to be considered as matching funds as long as the contributor of the in-kind match is an eligible entity as defined in Paragraph 47.
Paragraph 93: Eligible Access and Transport Services.
Comment: It is strongly recommended that the proposal to subsidize 50 percent of eligible health care providers' recurring monthly costs be approved.
Paragraph 98: Eligible Service Providers; and Paragraph 101: Use of non-traditional providers:
Comment: The proposal that any type of broadband provider can be eligible is strongly endorsed. The capability for the use of non-traditional as well as traditional providers is strongly recommended.
Paragraph 106: Proposing a flat discount of 50 percent for monthly recurring costs.
Comment: This proposal is strongly endorsed.
Paragraph 113: Opting into the Health Broadband Services Program.
Comment: This proposal is strongly endorsed, as it will assist in project sustainability. It is also recommended that the new rules that are adopted from this NPRM take effect immediately and that they be applied to any aspects of the Pilot Program that have not yet been completed.

- ***II. Comments that address Connectivity Speed and what is sufficient for Rural Health Care Networks:***

Paragraphs 20, 52, and 97: Minimum levels of Broadband Capability (speeds).
Comment: Paragraph 20 asks for comment on 10Mbps as a minimum threshold. Our belief is that 10Mbps is not close to being sufficient, at present and certainly not for the future. We recommend that 100Mbps symmetrical should be the baseline which the health infrastructure program seeks to deliver.

- ***III. Comments that address Performance Measures:***

Paragraphs 141 through 144: "Meaningful Use."
Comment: The proposal that Meaningful Use compliance be measured after some period of time (3 years was suggested) seems appropriate and is recommended.
Paragraphs 148 and 149: Data Gathering and Analysis.
Comment: The proposals contained in these paragraphs, to measure the impact of rural health care connectivity, seem appropriate and are recommended.

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Paragraph 3: Seeks comment on a package of reforms.
Comment: These proposal are strongly endorsed, particularly bullets 1 through 3.

Paragraph 3 – Fifth bullet: Seeks comment on ways to enhance ongoing program evaluation and implementation of performance measures to ensure that the public realizes benefits from the investment of universal service funding to improve broadband connectivity for health care providers.
Comment: To fully realize the benefits as described in the paragraph, it is recommended that, should the FCC approve the contents of the reforms outlined in the NPRM, that such approval should provide that these reforms take effect immediately and be applied to any aspects of the Pilot Program that have not yet been completed and where such reforms would logically apply.

Paragraph 19: Seeks comments as to whether broadband, as defined in Paragraph 20 following, is presently unavailable or insufficient for health IT.
Comment: The broadband speeds outlined in Paragraph 20 are insufficient for practical use of the full range of Health IT applications that are available currently (such as digital imaging), and that will be increased in the near future with electronic health record (EHR) requirements.

Paragraph 20: Seeks comment on setting a minimum threshold of 10 Mbps for broadband under the health infrastructure program.
Comment: The National Broadband Plan discusses what is needed in the near future. If the point of this NPRM is to provide a means to further the development of broadband infrastructure, the target must be more ambitious than merely meeting the near-future needs. Our analysis is that transmitting a CT scan at 10Mbps could take almost an hour from the originating facility. If the point of improved health infrastructure is to allow the benefits of improved medical applications to be accessed in rural environments, then it is contrary to that objective to place an arbitrary limit on the desired broadband speed that is so restrictive that, as a result, the benefits of the medical application cannot be reasonably attained. Almost by definition, the number of physicians in a rural location will be limited, but the bandwidth required for practical use of the desired health application remains constant. The health infrastructure in an acute care hospital must have the capability to deliver at least 100 Mbps upstream

and downstream to locations where skilled medical practitioners need to use medical and imaging applications.

Seeks comment on minimum levels of reliability, including physical redundancy.
Comment: While physical redundancy is strongly desirable, the reality is that full, diverse redundancy to all locations may be cost prohibitive. A standard that does seem achievable would be to have diverse redundancy on backbone routes (such as loops). For smaller, edge locations, it is recommended that the high-speed broadband be backed up by a diversely redundant commercial grade broadband (at lower speed, to be affordable).

Paragraph 22: Seeks comment on the means that applicants must use to demonstrate that adequate broadband is unavailable in the geographic area.
Comment: The first bullet outlines proposed requirements for surveys and proposed requirements for the survey preparer's qualifications to produce such a survey. The whole discussion of measurement of the level of broadband that may or may not exist in a geographical area misses the point: The point is, what is the level of broadband that the current providers are making available, and at what cost? The expenditure of significant time and effort to prove or disprove whether someone has fiber buried in the ground is meaningless if access to the fiber is not made available at an affordable cost. If there was a regulatory structure in place that was able to take full advantage of fiber and other high-speed broadband assets, such that their use could be maximized, then the survey would have meaning. However, since such a regulatory structure is not in place, the only question that is relevant is: What service is being made available today, at what price, to which locations in the geographical area?

The second bullet in Paragraph 22 has the same weakness: It seeks to measure what capability might exist in a geographical area, without taking into account whether, or not, the capability is being actively offered as a service to health care providers at an affordable cost.

The third bullet in Paragraph 22 suggests the appropriate means to move forward. Health care providers should be able to document that they have requested certain services, and that such services were either not being offered to them, or that such services were being offered at a cost that would not be sustainable for the health care provider to pay. It is assumed that by "a continuous period of not less than six months but this may vary widely to provider to provider by size of group," the NPRM is suggesting that the health care provider can demonstrate that it has made good faith efforts to seek affordable pricing over a period of not less than six months.

Paragraph 23: Seeks comment on whether the FCC should adopt financial criteria as mentioned on page 215 of the National Broadband Plan for applicants to show justification for the cost of new network deployment as compared to purchasing services from an existing network carrier.

Comment: The Rural Health Care Pilot Program requires that applicants show that the new network will be self-sustaining over time. In order to meet that standard, Pilot Participants have had to demonstrate to health care providers that the Pilot network is providing improved services at a lower cost than the commercial network providers are offering. In order to demonstrate this, the Pilot Participants and health care providers are making reasonable comparisons between the cost of being on the Pilot network and the cost of obtaining comparable services from commercial service providers. This is an achievable exercise.

The premise of Paragraph 23 is laudable. Certainly, it is appropriate to prepare financial plans that outline the budget, the projected cash flow, and the positive sustainability of the proposed network over at least ten years, and given the useful life of fiber optic networks, for even longer, from 15 to 20 years. It has been demonstrated that fiber optic cable is reliable, and that the capacity of fiber can be upgraded through periodic upgrades in optical equipment.

The financial metrics for long-term business plans that do not require as much annual revenue as is often needed for publicly traded companies allow for a broadband network to develop long-term arrangements, whether via ownership of assets or indefeasible rights of use of assets, which can spread the network cost over an extended period of time. The unknown element in such a scenario, however, is that it is difficult to estimate the level of service and the level of cost that the commercial providers may or may not provide in, for example, 15 years, to rural geographic areas. Thus it is difficult to argue, with certainty, about what conditions might exist 15 years in the future.

To keep analysis realistic, perhaps it would be appropriate to ask applicants to demonstrate that their projects:

- Provide a significantly improved level of service, at a cost to the health care provider that is significantly less than can be provided by service providers at the present time and for the foreseeable future.
- Provide a network infrastructure that will include a high speed, high capacity backbone that will be viable for at least twenty years.
- Provide budgetary and sustainability plans that demonstrate that the project will be self-sustaining in the long term, especially with the use of the 50% subsidy as outlined in Paragraph 93 of the NPRM. A realistic measure of the budget forecast would be for ten years.
- Provide benefits beyond ten years which, while difficult to quantify with certainty, do demonstrate the value of the project, in that fiber-based networks have useful lives of at least 20 years.
- Improve access to health care in rural areas in ways that can be estimated financially (e.g., use of EHR) and in ways that cannot be estimated financially (saving lives, improving rural health care).

- Due to transportation infrastructure shortcomings that access to care would be improved by local access to specialists and other services.

The objective of funding for health care networks should be that access to health care is measurably improved, quality of life for rural citizens is improved, certain health care costs are reduced (due to the use of EHR), while, at the same time, the long-term network cost is sustainable and reasonable.

Paragraph 30: Seeks comment on Cap on Amount Funded Per Project.
Comment: While understanding the desire to spread the benefits of the program geographically, it is also suggested that the final decision on a project should be based on its overall merit, not on a generally accepted cap. There should be some reasonable return on investment that relates to funds expended versus local community benefit.

Paragraph 31: Seeks comment on a Cap on Number of Projects Per Year.
Comment: While understanding the rationales proposed for an annual cap on projects, it is again suggested that the final decision on a project should be based on its overall merit, not on a generally accepted cap on the number of projects. Strong factors in merit selection would include the number of rural locations, and the demonstrated need in the geographic area.

Paragraphs 35 through 39: Seeks comment on Non-Recurring Costs, Network Design, Administrative Expenses, and Maintenance Costs.
Comment: This comment endorses the above named paragraphs. The standards and procedures proposed in these paragraphs seem appropriate and reasonable. Some of the experiences of the Pilot Program have shown that the approach taken in these paragraphs is warranted, in order to cover real, and unavoidable, costs that are involved in implementing high speed networks. In order to lower costs, considerable work is required to identify affordable options for high speed broadband and to design, engineer, and procure network elements to meet that objective.

Paragraph 37: Administrative Expenses.
Comment: In regard to the need for some amount of funding to support the process of "securing necessary agreements," it is strongly recommended that funding be allowed for legal review of contracts negotiated between the health care provider and the service provider. Additional comment on this topic is presented in the comment to Paragraph 42, Examples of Ineligible Costs.

Paragraph 38: Seeks Comment on "limitations on administrative expenses."
Comment: It is recommended that the limitation on such expenses be extended from the proposed 36 months to 48 months, for significantly large projects.

Paragraph 42: Examples of Ineligible Costs.
Comment: In Paragraph 37, Administrative Expenses, there is recognition that there are "costs incurred in preparing requests for proposals, negotiating with vendors,…" It goes on to state that the experience with the Pilot Program supports the need to provide some amount of funding for "administrative expenses in infrastructure projects, to support the process of designing the network and securing necessary agreements." This comment is addressing the unavoidable legal cost that is involved in securing necessary agreements. To develop contracts that are for multiple years, involve millions of dollars, and involve issues of service levels and liability, it would be irresponsible to preclude the use of contract attorneys to ensure that the appropriate measures are included in the contract. This comment is not proposing to open the door for a wide range of legal services, and is not proposing that attorneys be engaged in expensive, ongoing contract disputes. This comment does propose that a limited amount of attention to critical contracts by contract attorneys be eligible for financial support.

Paragraph 43: Billing and Operational Expenses.
Comment: This language seems appropriate with the assumption that administrative expenses are allowed, as per Paragraphs 35 to 39.

Paragraph 44: Seeks comment on Minimum Participant Contribution.
Comment: While understanding the importance of stakeholder commitment to a new broadband health network, the 15 percent match requirement has proved to be a significant burden to some entities involved in the Pilot Program, particularly in light of the current economic climate. If it is possible for some portion of the match to be waived, the benefits of improved health access could be more widely implemented. In any event, it is critical that the match requirement not be raised above 15 percent, especially to those entities who cannot pass on the increased costs of operations for faster speeds and the resulting improvement in services.

Paragraph 45: Seeks comment on placing the contribution requirement above 15 percent.
Comment: This is not a recommended path. While understanding the argument for a higher contribution, the current economic climate makes it extremely difficult for organizations to secure 15 percent, let alone a higher number.

Paragraph 46: Seeks comment on Evidence of Viable Source for the 15 Percent Contribution:
Comment: Recommend that participants be given 180 days, as opposed to the proposed 90 days, to demonstrate that they have a reasonable and viable source for the 15 percent matching funds.

Paragraph 47: Seeks comment on limitation of Eligible Sources for the matching funds.
Comment: While the concept remains valid, the recommendation is that in-kind contributions, reasonably but measurably defined, should be eligible to be considered as matching funds as long as the contributor of the in-kind match is an eligible entity as defined in Paragraph 47. This would allow real

assets, such as fiber optic strands, which are owned or controlled by an eligible entity, to be used as an Eligible Source. The metrics for measuring the value of such assets could be reasonably established.

Paragraph 49: Detailed Project Description in 90 days of notice of project eligibility.
Comment: There are real and significant costs involved in preparing the deliverables described in this Paragraph. While agreeing totally with the objective, it is assumed that notification that a project is eligible means that funding has essentially been approved, unless the participant does not provide the Project Description in an appropriate fashion. This comment is made to underscore the financial burden that will be placed on participants in preparing a detailed and appropriate Project Description, if it should turn out that funding is then denied. It is also recommended that 180 days be allowed for this process.

Paragraph 52: Seeks comment on Service Speeds and Scalability:
Comment: This comment endorses the proposals in the Paragraph, and adds the comment that the network backbone should be of sufficient capacity that symmetrical bandwidth of at least 100 Mbps should be attainable at a minimum for proposed network members, and that the network backbone should allow for scalability up to 1 Gbps per proposed network member via reasonable changes in equipment in the future (changing optical equipment on fiber).

Paragraph 53: Seeks comment on Health IT Purposes:
Comment: The benefit that will accrue from high speed broadband availability to healthcare facilities correlates directly to the state and nationwide plans to share healthcare data via health information exchanges as well as electronic health records. Additionally this increased bandwidth will allow expansion of necessary telemedicine applications which will assist in addressing issues of access in rural communities.

Paragraph 58: No Short-Term Leases.
Comment: It is appropriate that short-term leases not be allowed, as that would fly in the face of sustainability objectives for a project. However, the language in the Paragraph includes "short-term or operating leases." Here is the question: Is the intent of this Paragraph to also disallow long-term operating leases? If so, that presents a problem. In many situations, it may be that the most cost-effective long-term solution for a particular network segment is a long-term operating lease with a vendor, at the end of which the asset reverts back to the vendor. While this may not be ideal, it may be the best available solution, and if the solution covers a significant timeframe (minimum of 10 years, preferably 15 to 20 years), at the end of that period the value of the asset will have decreased, and the cost of replacing it may have also decreased, such that it makes sense financially.

Paragraph 59: Depreciation of Network Components.
Comment: This comment is merely to point out that the useful life of wireless equipment generally is a shorter time span than 10 to 20 years.

Paragraph 62: IRU:
Comment: The language concerning Term of the Agreement: "The health care provider is granted an exclusive and irrevocable right to use the facility funded by the health infrastructure program, for the remainder of facility's useful life," – while laudable, may be overly broad. The concern is that fiber providers, who typically provide a 20-year IRU, may balk at the phrase "facility's useful life." Question: Does that mean that, after the 20 years of the IRU have expired, the health care providers can still use the facilities in the future at no additional cost? Or does the language mean that the fiber provider must make the fiber available after 20 years, but that possible fees could be negotiated?

The second paragraph in Paragraph 62 is endorsed in concept. It is reasonable, however, that the health care provider's right to have access for repairs can be provided for *in the event that the fiber provider* does not respond to a request for repair, and thus become contingent upon the fiber provider's failure to promptly address the repair issue. This comment is suggested because it is not unreasonable for a fiber provider to take steps to protect the integrity of its network, and thus to want repair requests to be carried out by technicians of its own choosing. If the fiber provider does not address the issue promptly, then it is appropriate for the health care provider to have alternate means to solve the problem.

Paragraph 63: Capital Leases.
Comment: The language wishes to address the concern that prepayment of a lease can result in loss of capability and resources if the vendor defaults, and thus would prohibit prepayment. While this is definitely a valid concern, it raises an issue with sustainability. In the Pilot Program, long term leases were required (or strongly recommended) to be paid off within the initial 3 to 4 years. The reasoning for this was that the new health care network, after the Pilot funding had been expended, needed to be able to be sustainable. It was properly noted that if most of the Pilot funding was spent on recurring monthly costs, after the Pilot was completed, it would be extremely difficult for the network to continue functioning without a continuation of outside external resources. Note that there is also a requirement in the Pilot that that all funds must be expended within five years of the beginning of the network procurement process. If this requirement were eliminated, allowing funds to be used for a longer period, then a workable scenario would be as follows: To enhance prospects for network sustainability, and at the same time ensure that funds are not expended in prepayment for services that wind up being defaulted, the health care provider could be directed to take the following step for capital leases: Establish an escrow account into which the federal funds for the capital lease are deposited, only to be used to pay recurring costs for that specific lease contract throughout the term of the lease. If the lease was defaulted, the remaining funds could be used for a replacement for the same or similar services.

Paragraph 64: Provisions Applicable to all Contracts.

Comment: This comment focuses on the language pertaining to Performance Bonds. In the case of an IRU that covers 20 years of use, a performance bond may not be the appropriate means to remedy a problem.

Paragraphs 67 through75: On Shared Use.
Comment: This comment will initially discuss and recommend several overriding issues concerning Shared Use, and then comment more specifically on several paragraphs.

The premise of universal services for rural health care networks is based on the reality that high speed networks are either not available, or not affordable, for many health care providers in rural areas. In order to assure that any universal service funding for this purpose is used to maximum advantage, it was thought that the funding should be used only for rural networks that focus solely on health care. It has been allowed, however, that if a for-profit entity, or an otherwise ineligible entity, wished to share the cost of building the network, that could be allowed to occur within certain prescribed procedures, wherein, essentially, the health care provider and universal service funding pay only for the cost of the health care network. If an ineligible entity *at the front end of the procurement process* provided additional funds, such additional funds could pay the proportionate cost of the additional network build.

There were many additional caveats, which we can skip for the moment to get to an essential problem in the discussion. In order for additional bandwidth, or excess capacity, to be built, the process in the Pilot Program is such that the entirety of the arrangement, the whole deal if you will, has to essentially be worked out ahead of time, in a situation where time is limited. This has proven to be difficult for many entities to resolve.

So we have the real situation where both not-for-profit entities, such as government and schools, and for-profit entities, such as rural-based businesses, could benefit from being able to procure affordable broadband from a health care provider network. It would be in the public interest if such services could be used, because government and schools could provide better services, and because businesses could become more competitive and thus create and retain more jobs.

On the other hand, it can also be argued that such a use of universal service funds winds up looking like a government-aided subsidy to entities which are then competing unfairly against private sector broadband providers.

There are, however, policy procedures that could be established to make sure that the use of universal service-funded health care networks by “ineligible” entities works to the good of all, including broadband service providers:

3. Any excess capacity built into a health care network is made available on a wholesale basis to users and also to broadband service providers. A limit could be placed on leasing bandwidth, to ensure that a single entity did not gobble up all the excess capacity.
4. It could be stipulated that not-for-profit entities (government, public safety, schools, etc.) have a slightly reduced cost structure for using the services.
5. All net profits for the network that arise from such excess capacity (after legitimate network expenses are paid) shall be used by the health care provider network for network sustainability and network growth.

One of the advantages of this approach is as follows: Broadband service providers are understandably cautious about making large expenditures for broadband development in rural areas where demand is, by definition, limited. With the above outlined scenario for utilizing universal service funds for health care networks that can include excess capacity, the situation is set wherein broadband service providers are encouraged to make investments in rural areas because some of the cost of establishing broadband infrastructure and broadband backbone is eliminated.

How would the excess capacity be sized, so as not to overbuild unreasonably?
It is often pointed out that in the implementation of new broadband networks, the majority of the cost is involved with the construction itself, not in the actual broadband components. This is especially true of fiber networks, where the cost of trenching and laying conduit are much more than the cost of the fiber optic strands themselves.

In order to provide for rational sizing, it could be stipulated that, for a fiber-based health network, the amount of excess capacity (for non-health purposes) can be equal to the capacity for the health purposes, but cannot be significantly more than that, unless the business case and sustainability plan can demonstrate that there is clearly definable and clearly expressed interest on the part of not-for-profit and/or for-profit entities in the geographic area that justify an increase in excess capacity beyond that measure. Thus a 12-strand build for a health care network could be increased to 24 strands, or to a higher number of strands in the event that sufficient demand is evident and can be demonstrated to be such.

Paragraph 69: Fully-Distributed and Incremental Costs.
Comment: This can become incredibly complicated. In order to keep the process sufficiently understandable such that the universal service funding is actually used, it is proposed that:

4. All entities which are involved at the front end of the network build shall share the cost of the build proportionately to their share of the network assets or services. The health care funding shall pay for the initial build and the allowable excess capacity, as described above. If other non-health entities are interested, at the outset of the procurement process, in participating, such non-health entities should pay for their fully allocated costs, including construction.

5. Any entities which choose to make use of the network assets or services *after* such time as the network has been built shall pay a reasonable cost based on:
    a. The incremental cost for the new entity to use the assets or services; and
    b. A fee to use the network backbone. (This will address to some degree the issue of construction costs even though it is after the fact, and, in so doing, the new entities will contribute funds that can then be used as part of the sustainability and growth of the network. Such sustainability and growth adds value to connection to the network for the original funding entities, thus in some measure rewarding them for their initial investment.); and
    c. The regular and recurring monthly fees for network maintenance and an equipment-refresh fund.
6. The net profits (that are due to the network as a whole) from all such "new" entities shall be used for network sustainability and growth.
7. As an evaluation tool when the original application is being considered for initial federal funding, the initial cost of the health care provider network must be able to provided for, and to become sustainable, even if there is not significant growth beyond that which has been included in the initial business case and sustainability plan. The break-even point could have two scenarios, one for faster growth and one for slower growth. But even in the worst-case scenario, the network should still be able to become self-sustaining.
8. The intent here is to allow for excess network capacity via the universal service process, and thereby to provide the means for community and economic improvement, via a measured approach that takes steps to limit risk and to require realistic and rigorous planning, both for demand quantification and for financial analysis, without becoming such a convoluted process that it discourages involvement in the program.

Paragraph 76: Protecting Against Fraud, Waste, and Abuse.
Comment: Regarding the concept (first bullet) that eligible health care providers should own (or have an IRU) in all physical elements of the dedicated network, it is assumed that this refers to the dedicated *health* portions of the network. If the health care providers, at the front end, split the cost (for example) with non-health entities, such that non-health entities are sharing the cost of construction, etc., then it seems reasonable that the health entities would have an ownership interest in the health network portion, and the non-health entities would have an interest in the non-health portions.

The second bullet stipulates that all revenues from non-health entities must be used for network sustainability. It is assumed that this refers to revenues accruing to the health network, or the overall network, that are derived from leasing the network's excess capacity to non-health entities. The non-health entities (after paying their appropriate fees for the excess capacity) would be able to profit from their use of the excess capacity (or why would they utilize it).

Paragraph 77: Excess Capacity Disclosures.
Comment: Please see the comment in response to Paragraph 69 above. As alluded to in that paragraph, applicants would indeed disclose the estimated amount of excess capacity, would explain their approach to cost allocation, identify the non-health entities that are involved at the front end and the costs they would bear. Paragraph 69 outlines an approach to the "fully distributed" cost issue.

Paragraph 78: Additional Capacity for Community Use.
Comment: It is recommended that the FCC encourage the use of additional capacity in all categories listed in Paragraph 78. It is recommended that the approaches outlined in the comments to Paragraphs 69 and 76 be used to guide the cost allocation process.

Paragraph 79: Priority Preferences for Projects that Include Additional Capacity for Community Use.
Comment: As stated in the comment to Paragraph 78, it is recommended that inclusion of additional capacity be encouraged. In the first bullet in Paragraph 79, a difficult issue is raised: whether to prioritize those applications that provide for excess capacity. On the one hand, if the excess capacity will, per the application, be paid for by the non-health entities, then that would seem to qualify the applicant for additional consideration. On the other hand, a health-based application that shows definite need, even if it is unable to gather commitments from non-health entities, should not be unfairly penalized. The evaluation of applicants should be made on a case-by-case basis, without attempting to define an all-encompassing litmus test for approval. Situations will vary, and some latitude in the evaluation process must be allowed.

Paragraph 80: Other Considerations Regarding Additional Capacity for Community Use.
Comment: As outlined in the comments to Paragraphs 69 and 76, ownership by entities who provide funding for network assets at the front end, prior to procurement, should be able to have ownership interests. Non-health entities which seek to participate after the network has been constructed would be able, upon paying the fees outlined in the comment to 69, have a variable-term use of selected facilities, but not an ownership interest.

Paragraph 81: Physical Separation.
Comment: Where feasible, physical separation of fibers is ideal; however, this should not be strictly required, because it could increase costs significantly. Wavelength separation, with appropriate safeguards, would generally be adequate. For situations where dedicated bandwidth is being allocated, there would need to be prescribed, minimum security requirements.

Paragraph 82: Resale Provisions.
Comment: Please see comments to Paragraphs 69 and 76.

Paragraph 83: Vendor Cost Reporting Requirements.

Comment: There is general agreement with this paragraph, again with reference to comments to Paragraphs 69 and 76.

Paragraphs 85 and 86: Competitive Bidding.
Comment: These concepts seem appropriate.

Paragraphs 87 and 88: Designation of Successor Projects.
Comment: These concepts seem generally appropriate, with one recommendation. In the event that a project fails to meet a specified milestone, it is recommended that the project be given an opportunity for cure, to address the failure. The concern is that a project not be terminated unreasonably, but rather for significant failures to meet the agreed-upon objectives. It is assumed that this is the intent of the proposal.

Paragraph 93: Eligible Access and Transport Services.
Comment: It is strongly recommended that the proposal to subsidize 50 percent of eligible health care providers' recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet access, be approved. This proposal should include all not-for-profit health care providers, with the initial emphasis on rural areas *and* on smaller hospitals in urban areas, particularly in low-income areas.

Paragraph 96: Support for recurring costs of access over private dedicated networks or the public Internet for the provision of health IT.
Comment: In order for maximum positive impact, this proposal is supported, with the assumption that a high level of electronic security is mandatory.

Paragraph 97: Minimum levels of broadband capability (speeds).
Comment: As initially addressed in our comment to Paragraph 20, it is believed that 100Mbps symmetrical is the baseline which the health infrastructure program should seek to deliver for rural hospitals. To be practical, the 100Mbps minimum should be applied to small hospitals where the use of electronic imaging can measurably add to the ability of such locations to improve health delivery. Certain clinics may also fall into this category, and, practically speaking, the development of Health Information Exchanges, Regional Extension Centers, and the requirements of "Meaningful Use" for health service providers will all play a significant role in requiring increased bandwidth within the health care delivery system. *The backbone for health care networks must allow for scalability such that all doctors' offices can meet their connectivity needs.* There is no point building a backbone that does not meet the needs that will be present within a few short years. The proposal that larger health care centers have a minimum of 1Gbps is fully endorsed.

Paragraph 98: Eligible Service Providers.

Comment: The proposal that any type of broadband provider can be eligible is strongly endorsed. The capability for the use of non-traditional as well as traditional providers will measurable shorten the timeframe required to meet the nation's broadband objectives.

Paragraph 100: Support of installation charges.
Comment: The proposal that the one-time support for installation charges be raised from 25 percent to 50 percent is endorsed.

Paragraph 101: Use of non-traditional networks.
Comment: The proposal that health care providers should be able to receive support for their use of state, local, regional, and other non-traditional network providers, such as governmental entities, when that is the most cost-effective solution, is strongly endorsed.

Paragraph 102: Service Providers deploying new facilities.
Comment: This comment is merely to confirm that this Paragraph addresses a situation where a service provider is attempting to recover more than $500,000 through non-recurring charges on a one-year contract with health care providers, where recurring charges will also be levied on the health care provider, probably monthly. The concern is that this Paragraph should not inadvertently interfere with the intent of Paragraph 30, and should not interfere with legitimate attempts by non-traditional (and traditional) service providers to meet the objectives of the Rural Health Care Support Mechanism.

Paragraph 106: Proposing a flat discount of 50 percent for monthly recurring costs.
Comment: This proposal is strongly endorsed.

Paragraph 109: Within a flat rate of 50 percent, should affordability metrics still be incorporated for higher subsidies for rural health care providers?
Comment: Here is a possible approach: If a rural area has the benefit of a federally funded Pilot or Healthcare infrastructure network, then the 50 percent rate for recurring costs seems fair, as the federal funding has already provided an improved avenue for improved broadband. If, on the other hand, a rural area has not had the advantage of a federally funded infrastructure network, and if affordability is an obvious impediment to use of broadband even with a 50 percent subsidy, then additional metrics based on affordability could come into play.

Paragraph 110: Competitive Bidding.
Comment: Here is one recommendation to ease the process, while still requiring bidding: In some situations, a health care network may seek to include all health care locations in an area in a bidding process, but be unable to receive Letters of Agency from each of the locations. Assuming that a majority of the health care providers in the area do, indeed provide an LOA, such that they can then be listed in the 465 Attachment, it should be allowable that the posted RFP (and advertised RFP) can also include

other health care locations in the immediate vicinity. If, after bids are received and evaluated, some of the health care locations that were not listed in the 465 Attachment, but WERE included in the RFP, should choose to join the health care network per the RFP bid responses, this should be allowed without having to re-bid these particular locations all over again.

Paragraph 112: On Multi-year Contracts.
Comment: This proposal is endorsed.

Paragraph 113: Opting into the Health Broadband Services Program.
Comment: This proposal is strongly endorsed.

Paragraph 116: Eligible Health Care Providers, expansion of categories: Administrative Offices.
Comment: The proposal as worded in Paragraph 116 seems appropriate and is endorsed.

Paragraphs 117 and 118: Reasons to expand to cover some Administrative costs.
Comment: This proposal is strongly endorsed. There are real costs that deserve to be covered, so as not to discourage development of improved access to lower-cost, high speed broadband health networks.

Paragraph 119: Support for off-site administrative offices.
Comment: Rather than focus on the cost of off-site administrative offices, the proposal should be focused on the real cost of administrative work to implement and operate the health care network, whether such work is performed on-site or off-site. Regarding off-site administrative offices, what is the definition of "controlled?" For example, if a group of hospitals has out-sourced the administration of critical elements, the entity that is performing that work may be considered to be eligible. In such a case, this comment recommends that appropriate and relevant portions of an off-site administrative office should be eligible, on a pro-rated basis, for support as an eligible health care provider. This comment also notes that the last sentence in the Paragraph seems to contradict the possibility of pro-rating: "…allow eligible health care providers to seek support for off-site administrative offices *only* in those instances where the … office is used *primarily* for performing services integral to the provision of health care…" (italics added for emphasis).

As an additional note, we raise the consideration of the use of remote applications, remote computing, so-called cloud computing, etc., in the treatment of rural patients. If a health care provider is tending to the needs of patients by improving health care with the use of cost-effective remote applications, such activity may involve an administrative cost. Such costs would be small on an incremental basis, but could become significant with larger usage of such approaches. Perhaps these administrative costs should be included in some capacity as being eligible for health care support, in order to encourage wider dissemination.

Paragraphs 120 and 121: Data Centers off-site.
Comment: The costs of connecting off-site data centers that are integral to the operation of the health care network should be supported.

Paragraph 122: Data Centers with several purposes.
Comment: The proposal that support of off-site data centers should be proportional to their use in the operation and functioning of the health care network and applications is strongly endorsed. The support would be on a pro-rated basis.

Paragraphs 123 and 124: Skilled Nursing Facilities.
Comment: The proposal that skilled nursing facilities be included as eligible health care entities is strongly endorsed.

Paragraph 125: Facilities with both skilled nursing services and custodial services.
Comment: It is recommended that the following standard be used to determine whether a facility is considered an eligible health care provider: Does the facility make use, or would it seek to make practical and relevant use, of health care applications that depend on the use of high speed broadband? If the answer is yes, for at least 25 percent of its average number of patients, then the facility should be deemed eligible.

Paragraphs 126 and 127: Renal Dialysis Centers and Facilities.
Comment: This proposal is endorsed, with the added emphasis as provided in the comment to the preceding paragraph.

Paragraphs 128 and 129: Annual Caps and Prioritization Rules.
Comment: The proposals are generally endorsed. The only comment is that some amount of latitude may be prudent to be provided, such that the Commission can adjust the cap for infrastructure projects in a single year if the number of high-value projects should warrant such.

Paragraph 130: Procedures if worthy requests for available funds in a given year exceed the funding levels.
Comment: Elements of both proposals (pro-rating and HPSA score) seem relevant, and perhaps both options could be used, as appropriate, on an annual basis. Return on investment should be considered as well as current level of connectivity to create the most efficient use of funds that will impact the largest number of rural patients.

Paragraph 131: How to prioritize funding for infrastructure programs in a given year.

Comment: The total number of rural health care providers seems to be the most relevant single measure. Consideration should include the most cost effective use of funds that relates directly to the provision of primary care services and local capabilities.

Paragraph 137: Offset Rule.
Comment: The proposal outlined in this paragraph, that offsets generally be eliminated for participants in the health services program, is endorsed.

Data Gathering and Performance Measures
Paragraph 141:
Comment: The proposal that Meaningful Use compliance be measured after some period of time (3 years was suggested) seems appropriate and is recommended. The access to information from a broad array of healthcare organizations will allow a detailed picture of local health issues and resource consumption. These will be critical aspects as we begin to move forward with implementation of the electronic health records and statewide health information exchange. This model will allow for the exchange of information to develop in concentric circles that begin with primary care physicians and primary care organizations.

"Meaningful Use."
Paragraph 142:
The recently established meaningful use criteria require connectivity speed to physicians' offices of 10 Mbps and 100 mbps to rural acute care organizations in order for them to meet the meaningful use requirements that include interoperability, health information exchange and communication with an expanding circle of healthcare organizations.

Paragraphs 143-147:
We would encourage that any measurement of performance improvement be measured over a period of time that would begin three to five years from now due to the relatively low rate of adoption of electronic health records and the absence of consistent statewide health information exchanges.

Paragraphs 148 and 149: Data Gathering and Analysis.
Comment: The proposals contained in these paragraphs, to measure the impact of rural health care connectivity, seem appropriate and are recommended.